16-1-2023

To

The Rt Hon Preet Kaur Gill MP

Mr R Burden, Chair , Healthwatch Birmingham

Thank you both for your continued involvement in this matter. We are contacting you again following our discussions with you last week as well as fresh revelations by the BBC on Friday 13th January about the management and culture at UHB, damaging patient safety and staff morale. These revelations were of such a serious nature that soon demands were made for an independent inquiry, which only grew stronger once the scale of the problems became clear and more facts surfaced such as a Unison report about UHB, which made a comparison with the Mid Staffs scandal.

The ICB reacted to the initial allegations by immediately commissioning three reviews, which In our view are not fit for purpose. In this letter we will focus particularly on the first review, led by Mike Bewick.

Summary:

–We have grave concerns about the ICB's reviews into UHB, which were extraordinarily commissioned in haste without involving those most seriously harmed by toxic trust management actions.

-We are concerned that a review by an NHS insider, overseen by NHS bodies with conflicts of interest, is woefully inadequate for the task and will seriously fail patients and staff.

-We believe that the haste and direction of the ICB's reviews are aimed at controlling the narrative, and not a genuine resolution. The current Terms of Reference are unacceptable to us.

-The Secretary of State is reported to be reassured that NHS England is in overall control, but NHS England's West Midlands region has a history of serious failures, including Mid Staffs, maternity failings at Shrewsbury and Telford, unsafe care at Worcestershire Acute and the Ian Paterson breast surgery scandal at Heartlands.

-UHB is a story of closed cultures and systemic failures, including by the regulators. The CQC in particular had a chance to stop the toxicity years

ago and failed to disclose important data, such as a damning dossier sent to it by UNISON.

-The detail of the BSol ICB's arrangements for a review betray a fundamental lack of understanding of the problem. Moreover, UHB's public response to the scandal reveals an organisation still in denial. The current plans will not surmount these difficulties: only a forensic, external and independent investigation will enjoy the confidence of UHB's victims and the public at large.

Our objections against the Bewick review include:

1. The involvement of Birmingham and Solihull Integrated Care Board (ICB)

1.1 The reviews are commissioned by the ICB board, which has strong links with UHB. There is a clear conflict of interest here:

-As commissioner of healthcare for the local population, BSol CCG, the recent forerunner of the inchoate BSol ICB, neglected to treat the performance failings of its biggest acute provider (UHB) with anything like the attention they required.

-The former CEO of BSol CCG, Paul Jennings, is now a non-executive director at UHB.

-Two BSol ICB Board members are former senior employees of UHB.

1.2 David Rosser, the previous CEO of UHB, was offered a new position as regional strategic director for Digital Health and Care at a time that UHB ranked 119 out of 120 in the table of English hospital trusts, its cancer waiting times were among the worst in the country, and UHB had the country's longest waits for cardiac surgery, resulting in devastating impact on patient care. Additionally, while David Rosser was at the helm, the trust's own Freedom To Speak Up Guardian referred to a climate of fear and bullying in his report. As you rightly stated: "There has been a clear failure of leadership, a failure of governance and a failure of regulation." The ICB declared in its notes of its latest board meeting dated 9 January 2023 that the 'contribution David made….leading the system through an unprecedented period was enormous'.

1.3 David Rosser's new role within the region will mandate a continued close working relationship with BSol ICB and he remains in a position to influence the review. We understand that the ICB was involved in his recent appointment and that after starting his new role, David Rosser was still invited to attend the above meeting of the ICB. The lack of transparency and detail about David Rosser's new role, his appointment,

the funding of his post and links to the ICB undermines accountability and public confidence in this review.

1.4 As the ICB review is not a public inquiry with statutory powers, its chair does not have the power to ungag (ex) employees who have signed non-disclosure agreements. As it is known that UHB has used these clauses to silence (ex) staff, their voices won't be heard in this review.

1.5 Preet Gill's letter to Steve Barclay MP also argues convincingly why an independent inquiry is needed instead of an ICB led review.

2. The appointment of Mike Bewick

2.1 Mike Bewick, who used to work for NHSE as Deputy Medical Director, is very much part of the medical and NHS senior establishment. Despite the fact that various regulators and medical institutions, such as the CQC and NHSE, were or should have been aware of the problems at UHB, they took no or insufficient action. The fact that the CQC did not disclose a UNISON report which corroborated our concerns only highlights the possible complicity of the regulators, a recurring theme in other NHS scandals. For these reasons, Mike Bewick is unsuitable to lead any review of UHB.

2.2 Even if Mike Bewick does not have direct links with UHB/ Dr Rosser, his indirect connections are reason for concern in our view :

-Mike Bewick was Bruce Keogh's deputy at NHS England. Bruce Keogh used to work at UHB (1996-2004).

-Bruce Keogh and David Rosser were colleagues at UHB and they co-authored an article together on Weekend Mortality.

-Mike Bewick and Dame Julie Moore, previous CEO of UHB, are current members of the Centre for Progressive Policy Advisory group.

2.3 As a former Deputy NHS MD (to Professor Sir Bruce Keogh), Mike Bewick is poorly placed to undertake an unprejudiced review: there is a risk of bias, if only unconscious, resulting from not only his duties as an NHSE employee but his discussions with Bruce Keogh as an ex-UHB employee.

2.4 Moreover, we understand that Mike Bewick has reportedly made comments which suggest he had pre-judged the outcome of the reviews already, and seems to be thinking about splitting UHB up. This would be a deflective manoeuvre. It is the toxicity of the management culture that is the issue, not the size of the trust. Other trusts of a similar size have not had the same problems. If it is true that there are signs of a pre-

determined outcome, this again suggests that Mike Bewick is not suitable to lead this review.

2.5 Had we been consulted, we would have made clear that the appointment of a senior NHS insider was completely unacceptable because of inherent conflicts of interest. An independent inquiry, led by a truly impartial outsider such as a judge, would be far more suitable to deal with the scope and nature of the concerns about UHB.

3. The current Terms of Reference are unacceptable to us

3.1 To the best of our knowledge none of the victims of UHB's behaviour have been invited to participate in the drawing up of the ToR. This is not only disrespectful but also a missed opportunity to ensure effective ToR through discussions with those who have first hand experience of the culture at UHB and the impact on staff.

3.2 According to the first term of reference the findings of the report drafted by Mr Nikolousis into concerns over the care of patients with haematological conditions will be reviewed with UHB haematologists to determine whether further expert review should be recommended. BSol ICB demonstrates no understanding of the problem of a dysfunctional department. We understand that the report should be shared with the members of the department but they should not be granted the power to veto the commissioning of any further external investigation.

3.3 Additionally the second term of reference refers to 'the appropriateness of the governance processes which apply when determining whether or not to make a referral to a professional regulator such as the GMC, including an overview of the TR case'. Again, BSol ICB demonstrates little understanding of the issues, of which the decision to refer to a professional regulator is just one small strand. This is too loosely written and we believe this is a consequence of a lack of ICB consultation with those of us who were subject to referrals.

3.4 Emphasis must be placed on a detailed examination of each element of such cases including, inter alia, the timing of the referral; the accuracy of the content of both the referral and subsequent communications. The ICB terms of reference are too weak and non-specific to explore biased and or malicious management behaviour.

3.5 The ToR also miss out a critical issue: a flawed Fit and Proper Person process by the trust on David Rosser. The trust has admitted to at least one FPPR review in response to multiple referrals to the CQC under Regulation 5. The trust appointed a subordinate to investigate David Rosser, someone who was not even a board member, and she was

assisted by a lawyer from Bevan Brittan, a firm retained by the trust. Additionally, the MHPS designated board member in the Tristan Reuser case, was also involved in the FPPR investigation. This was therefore the opposite of an independent exercise. David Rosser was deemed to be a Fit and Proper Person despite his behaviour relating to Tristan Reuser's MHPS investigation, dismissal and employment case, including misleading the regulator for which Dr Rosser received a GMC warning. Had the ICB consulted with us, we would flagged the FPPR matter as another area for investigation.

3.6 The CQC had a chance to stop the bullying and toxicity at UHB years ago, when the FPPR referrals were first made about UHB but failed to do so. It follows that a localised review of UHB which does not even look at FPPR issues, let alone at any regulatory actions, will hardly scratch the surface of the truth.

3.7 As flagged at the meeting with Richard on 13 January, there are concerns about financial transparency at UHB, which stopped producing routine financial transparency data after 2017. The trust persisted with this despite run ins with the ICO after complaints by the public who filed FOI requests and questions have to be asked about this financial secrecy. We would have raised this with the ICB had they troubled themselves to consult us.

3.8 The ICB of course is conflicted in this matter and in general, as it too had a responsibility in its predecessor form for oversight of UHB's performance.

3.9 Finally, the Terms of Reference extend well beyond the core issues to embrace other matters that are already well documented. This represents a wasteful distraction from the allegations that the review should focus on, if not wilful obfuscation.

4. Methodology

4.1 There is no reassurance that all victims will be offered a confidential interview.

5. Conclusion

5.1 In our view, Birmingham and Solihull Integrated Care Board took precipitate action without involvement of all stakeholders in order to fully control the process and therefore the outcome. This is unacceptable.

5.2 The impact of UHB's actions on victims' lives and the effect on patient safety cannot be underestimated. Careers have been destroyed and families damaged by the emotional, health and financial and health

problems that ensued. We have fought for many years to uncover and then expose the truth. Having been largely ignored by the NHS and its regulators we have finally achieved this only with the help of the media. Now that our concerns have been recognised, it is incumbent upon us to ensure that they are appropriately investigated: independently, and without fear or favour. We owe this to ourselves, our families and UHB's staff. Most of all we owe it to the patients at UHB whose safety has already been compromised and those at future risk.

5.3 It is surely clear to everyone, including BSol ICB, that the very nature of a central allegation, that there exists at UHB a "mafia-like culture", demands a truly independent investigation. You have, quite rightly, called for this yourself. The current position is thus unacceptable to us. We would urge you both to use your influence in order to generate an investigation that will enjoy the confidence of all.

We ask you politely to forward our letter to all those who have approached you, so they are able take note of our concerns.

Yours sincerely,

Manos Nikolousis, Chairman Medical School EUC, Associate professor of hematology

Prof John Watkinson, consultant ENT surgeon
Tristan Reuser , consultant ophthalmic surgeon

CC

Parliamentary Health select committee:

Steve Brine MP

Paul Blomfeld MP
Martyn Day MP
Mrs Paulette Hamilton MP
Rachael Maskell MP
Taiwo Owatemi MP
Lucy Allan MP
Paul Bristow MP
Chris Green MP
Dr Caroline Johnson James Morris MP

Steve Barclay, Secretary of State for Health and Social Care, MP